WISCONSIN MEDICAID
PRIOR AUTHORIZATION / EVALUATION AND TESTING ATTACHMENT (PA/ETA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Evaluation and Testing Attachment (PA/ETA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Performing Provider
Enter the name and credentials of the therapist who will be performing the evaluation or testing.

Element 5 — Performing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the performing provider. (Not required for providers in 51.42 Board-operated clinics.)

Element 6 — Telephone Number — Performing Provider
Enter the performing provider's telephone number, including area code.

SECTION III — DOCUMENTATION

Element 7
Document the type of evaluation being requested and why it is needed. For instance, the evaluation may be a competency examination or it may be necessitated by the need to confirm a diagnosis. If the recipient was referred for evaluation, indicate who made the referral and why. Indicate how the results of the evaluation or testing will be used. Indicate how the recipient will benefit (e.g., indicate if the evaluation might be used to place the recipient in a less restrictive setting, or to obtain guardianship which would be in the recipient's best interests). Providers requesting retroactive authorization must document the emergency situation or the court order that justifies such a request and indicate the initial date of service.

Element 8
Indicate the specific tests, instruments, or procedures which will be used to conduct the testing or evaluation. These tests, instruments, or procedures must be those accepted as standard of practice for the psychiatrist/psychologists (e.g., proposed psychological testing instruments should be listed in the latest edition of the Mental Measurements Handbook).

Element 9
The provider needs to indicate what other evaluations or testing they are aware of that have been done on the recipient in the past two years and why the current request is not duplicative. Where possible, attach copies of the evaluations, tests, or summaries of their results.

A physician's prescription is not required for these evaluations and testing services.

Element 10 — Signature — Performing Provider
Enter the signature of the performing provider.

Element 11 — Date Signed
Enter the month, day, and year the PA/ETA was signed (in MM/DD/YYYY format).

Element 12 — Signature — Recipient (optional)
Enter the signature of the recipient.

Element 13 — Date Signed
Enter the month, day, and year the PA/ETA was signed (in MM/DD/YYYY format).